

AMENDED IN SENATE APRIL 20, 2005

AMENDED IN SENATE APRIL 4, 2005

**SENATE BILL**

**No. 397**

**Introduced by Senator Escutia**

**(Coauthors: Senators ~~Kuehl~~ Alquist, Kuehl, Romero, and Vincent)**

**(Coauthor: Assembly Member Pavley Coauthors: Assembly Members  
Laird and Pavley)**

February 17, 2005

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An act to add Section 11174.11 to the Penal Code, relating to elder death.

LEGISLATIVE COUNSEL'S DIGEST

SB 397, as amended, Escutia. Elder death review teams.

Existing law authorizes counties to establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder abuse or neglect cases.

This bill would require every skilled nursing facility and residential care facility within a county that has a county elder death review team to notify, as specified, the chair or chair designee of the team via fax or e-mail whenever there is a death of an elderly resident at the facility.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 11174.11 is added to the Penal Code, to  
2 read:

1 11174.11. (a) Every skilled nursing facility, as defined in  
2 subdivision (c) of Section 1250 of the Health and Safety Code,  
3 and residential care facility, as defined in subdivision (j) of  
4 Section 1568.01 of the Health and Safety Code, within a county  
5 that has a county elder death review team shall notify the chair or  
6 chair designee of the team via fax or e-mail whenever there is a  
7 death of an elderly resident of the facility.

8 (b) The notification shall be made as soon as possible, but no  
9 later than 24 hours, after the death of the resident.

10 (c) The notification shall be made on a form created by the  
11 elder death review team, and shall include the resident's name,  
12 gender,~~and~~ date of birth,~~and~~ the date and location of the  
13 resident's death, *whether there was a "do not resuscitate (DNR)"*  
14 *order or advanced directive in place for the patient, and whether*  
15 *the elder was receiving hospice care.*

16 (d) The State Department of Health Services and the State  
17 Department of Social Services shall monitor compliance with  
18 this section